What is the difference between Medicare and Medicaid?

Medicare is a federal **health insurance** program. It is the nation's largest federal health insurance program, covering nearly 40 million Americans. It is basically the same everywhere in the United States and is run by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal government.

Medicaid is a joint federal and state **health care assistance** program run by state and local governments within federal guidelines set by CMS. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

The differences between Medicare and Medicaid are summarized in the table on page 5.

Medicare and Medicaid work together to pay health care costs for low-income persons. Medicare pays first. Then Medicaid will cover many (sometimes all) of the costs not covered by Medicare. Most health care costs are covered if you qualify for both Medicare and Medicaid.

To find out if you qualify for Medicaid:

Contact the Arkansas Department of Health and Human Services
Medicaid Office
PO Box 1437, Slot 1100
Little Rock, AR 72203
Toll-Free: 1-800-482-8988 or (501) 682-8304

What services are covered by Medicare?

- **Preventive Services** such as bone mass measurements, colorectal cancer screening (fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema), diabetes services and supplies, glaucoma screening, mammogram screening, pap test, pelvic examination, clinical breast exam, prostate cancer screening [digital

rectal examination and Prostate Specific Antigen (PSA) Test], and vaccinations.

- Ambulance services when other transportation would endanger your health,
- Artificial eyes,
- Artificial limbs (prosthetic devices and their replacement parts,
- Braces - arm, leg, back, and neck,
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation,
- Emergency care,
- Eyeglasses - one pair of standard frames after cataract surgery with an intraocular lens,
- Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility,
- Kidney dialysis,
- Medical nutrition therapy services for people who have diabetes or kidney disease (unless you are on dialysis) with a doctor's referral. The medical nutrition therapy services will be covered for 3 years after the kidney transplant,
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies,
- Outpatient prescription drugs (very limited). For example, some oral drugs for cancer,
- Prosthetic devices, including breast prosthesis after mastectomy,
- Second surgical opinion by a doctor (in some cases),
- Services of practitioners such as clinical social workers, physician assistants, and nurse practitioners,
- Telemedicine services in some rural areas,
- Therapeutic shoes for people with diabetes (in some cases),
- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and when performed at Medicare-certified facilities), and

- X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests.

Medicaid covered services are either federally mandated or optional (chosen to be covered by the State).

Medicaid services mandated by the federal government include:

- Child Health Services - Early and Periodic Screening, Diagnosis and Treatment (EPSDT),
- Family Planning,
- Federally Qualified Health Centers (FQHCs),
- Home Health,
- Hospital, both inpatient and outpatient,
- Laboratory and X-ray
- Nursing Facilities (for persons over age 21),
- Nurse Midwife,
- Nurse Practitioner (Family and Pediatric),
- Physician, and
- Rural Health Clinics.

Optional Medicaid services chosen by Arkansas include:

- Ambulatory Surgical Center Services,
- Audiological Services (EPSDT, Under Age 21),
- Targeted Case Management for Pregnant Women,
- Targeted Case Management for Recipients Age 21 and over,
- Targeted Case Management for Developmentally Disabled Recipients Under Age 21,
- Targeted Case Management Services for Recipients (EPSDT, Under Age 21),
- Targeted Case Management Services for Recipients Age 60 and Older,
- Certified Registered Nurse Anesthetist (CRNA),
- Child Health Management Services (EPSDT, Under Age 21),
- Chiropractic Services.

- Dental Services (EPSDT, Under Age 21).
- Developmental Day Treatment Clinical Services (DDTCS),
- Domiciliary Care Services,
- Durable Medical Equipment (DME),
- End-Stage Renal Disease (ESRD) Facility Services,
- Hyperalimentation Services,
- Hospice Services,
- Inpatient Psychiatric Services Under Age 21,
- Inpatient Rehabilitative Hospital Services,
- Intermediate Care Facility Services for Mentally Retarded,
- Medical Supplies,
- Nursing Facility Services (Under Age 21),
- Occupational, Physical, Speech Therapy Services, Orthotic Appliances (Under Age 21),
- Personal Care Services,
- Podiatrist Services,
- Portable X-ray Services,
- Private Duty Nursing Services (for Ventilator-Dependent All Ages and High-Tech Non-Ventilator Dependent Persons) (EPSDT, Under 21),
- Prescription Drugs,
- Licensed Mental Health Practitioner Services (Under Age 21),
- Rehabilitative Services for Persons with Mental Illness (RSPMI),
- Rehabilitative Services for Persons with Physical Disabilities (RSPD),
- Respiratory Care Services (EPSDT, Under Age 21),
- Ventilator Equipment,
- Visual Services, and
- Transportation Services (Ambulance, Non-Emergency).

Medicare versus Medicaid

Questions	Medicare	Medicaid
Who is covered?	Persons age 65 and over, some people with disabilities under the age of 65, and people in end stage renal disease (ESRD)	Certain individuals and families with low incomes and resources (families with dependent children and persons who are either 65 years of age and older, legally blind or permanently and totally disabled).
How is eligibility determined?	● Age 65 and over – eligibility is based on Social Security or Railroad Retirement ● Under 65 – eligibility is based on disability ● End stage renal disease (ESRD) – eligibility at any age	Eligibility based on financial need, with state-specific guidelines.
Who administers the program?	Administered by insurance companies under contract to process Medicare claims. For questions, call Medicare at: 1-800-633-4227 or Arkansas Foundation for Medical Care (AFMC) at: 1-888-354-9100.	Administered by the federal government through state and local governments, following federal and state guidelines.
How is program financed?	Medical bills are paid from trust funds financed by monthly premiums paid by the beneficiary and through payroll tax deductions.	Medical bills are paid by federal, state and county tax dollars. The federal government's share of costs (based on per capita state income) is 75% in Arkansas. Patients usually pay no part of the costs for covered medical expenses, although a small co-payment may sometimes be required.
Regulations	Same in all states	Vary from state to state
Deductibles and co-payments	Beneficiaries are responsible for paying deductibles, co-payments and Part B (Medical) premiums.	Medicaid can sometimes help to pay Medicare deductibles, co-payments and premiums.
What is covered?	Hospital (Part A) and medical benefits (Part B). **NOTE:** preventive care and long-term care benefits are limited.	Comprehensive Benefits, including preventive care, long-term care and selected items not covered under Medicare such as prescriptions, some transportation services, dental work, eyeglasses, and hearing aids.